* The original of this document contains information which is subject to withholding from disclosure under 5 U.S.C. 552. Such material has been deleted from this copy and replaced with XXXXXXX's.

September 9, 2002

DEPARTMENT OF ENERGY
OFFICE OF HEARINGS AND APPEALS

Hearing Officer's Decision

Name of Case:	Personnel Security Hearing
Date of Filing:	April 1, 2002
Case Number:	VSO-0528

This Decision concerns the eligibility of XXXXX (the individual) to hold an access authorization[1] under the regulations set forth at 10 C.F.R. Part 710, entitled "Criteria and Procedures for Determining Eligibility for Access to Classified Matter or Special Nuclear Material." The individual's access authorization was suspended by the Manager of a Department of Energy (DOE) Operations Office (the Operations Office) pursuant to the provisions of Part 710. Based on the record before me, I am of the opinion that the individual's access authorization should be restored.

I. *Background*

The individual is an employee of a contractor at a DOE facility, and has held a security clearance since May 1994. After the individual was arrested for Public Intoxication in July 2001, the Operations Office conducted a Personnel Security Interview (PSI) with the individual on July 30, 2001. *See* DOE Exhibits 1-5, 1-6. Because the security concern remained unresolved after that PSI, the Operations Office requested that the individual be interviewed by a DOE consultant psychiatrist (DOE psychiatrist). The psychiatrist interviewed the individual on November 6, 2001, and thereafter issued an evaluation to the DOE, in which he opined that the individual suffered from Substance Dependence, Alcohol with Physiological Dependence in Early Full Recision. *See* DOE Exhibit 3-7. The Operations Office ultimately determined that the derogatory information concerning the individual created a substantial doubt about his eligibility for an access authorization, and that the doubt could not be resolved in a manner favorable to the individual. Accordingly, the Operations Office suspended the individual's access authorization, and obtained authority from the Director of the Office of Safeguards and Security to initiate an administrative review proceeding.

[1] Access authorization is defined as an administrative determination that an individual is eligible for access to classified matter or is eligible for access to, or control over, special nuclear material. 10 C.F.R. § 710.5(a). Such authorization will be referred to variously in this Decision as access authorization or security clearance.

The administrative review proceeding began with the issuance of a Notification Letter to the individual. *See* 10 C.F.R. § 710.21. That letter informed the individual that information in the possession of the DOE created a substantial doubt concerning his eligibility for access authorization. The Notification Letter included a statement of that derogatory information and informed the individual that he was entitled to a hearing before a Hearing Officer in order to resolve the substantial doubt regarding his eligibility for access authorization. The individual requested a hearing, and the Operations Office forwarded the individual's request to the Office of Hearings and Appeals (OHA). The Director of OHA appointed me as the Hearing Officer in this matter.

At the hearing convened pursuant to 10 C.F.R. § 710.25(e) and (g), I took testimony from the individual, a DOE personnel security specialist, the DOE psychiatrist, the individual's treating physician, his ex-wife, one of his managers, two of his friends, and a leader of AA meetings attended by the individual. Both the individual and the DOE Counsel submitted exhibits. I closed the record upon receiving the transcript of the hearing.

I have reviewed and carefully considered the evidence in the record. I have considered the evidence that raises a concern about the individual's eligibility to hold a DOE access authorization. I have also considered the evidence that mitigates that concern. I conclude, based on the evidence before me and for the reasons explained below, that the security concern has been resolved, and that the individual's access authorization should be restored.

II. *Analysis*

A. *The Basis for the DOE's Security Concern*

As indicated above, the Notification Letter issued to the individual included a statement of the derogatory information in the possession of the DOE that created a substantial doubt regarding the individual's eligibility for access authorization. In the Notification Letter, the DOE characterized this information as indicating that the individual (1) "is a user of alcohol habitually to excess, or has been diagnosed by a psychiatrist as alcohol dependent or as suffering from alcohol abuse;" (2) has "an illness or mental condition which in the opinion of a psychiatrist causes, or may cause, a significant defect in the judgment or reliability" of the individual; and (3) "has engaged in unusual conduct or is subject to circumstances which tend to show that he is not honest, reliable, or trustworthy; or which furnishes reason to believe that he may be subject to pressure, coercion, exploitation or duress which may cause him to act contrary to the best interest of the national security." *See* 10 C.F.R. § 710.8(h), (j), (l). The statements were based on the individual's prior alcohol use and alcohol-related arrests, as well as the diagnosis by the DOE psychiatrist that the individual suffered from Substance Dependence, Alcohol with Physiological Dependence in Early Full Recision. DOE Exhibit 2-7.

The individual's first significant problem related to alcohol was a 1986 arrest for assault and illegal consumption of alcohol, when he was 19 years old. Notification Letter at 4. In November 1991, police were called to the scene of a domestic disturbance that occurred after the individual had been

drinking. The individual, who was in the military at the time, was ordered to attend an alcohol rehabilitation program at his base, followed by attendance at AA meetings over the subsequent six to seven months. Transcript of Hearing (Tr.) at 20. In the fall of 1992, the individual was found unconscious in a parking lot outside of a restaurant, and upon being taken to the hospital was found to have a blood alcohol content of 0.316 percent. Tr. at 22. In March 1993, the individual was charged with driving while intoxicated by military police at his base, for which he was fined $300 and "reduced in grade." Tr. at 19-20.

When the individual was interviewed in May 1994 in connection with his application for a DOE security clearance, the individual stated that he had not drunk since the March 1993 DWI incident, and that he did not intend to drink alcohol in the future. DOE Exhibit 1-2. The DOE granted a security clearance at that time.

In November 2000, during a routine reinvestigation of the individual's suitability for a clearance, the individual informed the DOE that he had been drinking once or twice a year, but that the last time he had drunk was on a cruise in November 1999, when he consumed three or four beers and became intoxicated. DOE Exhibit 4-3 at 13, 23-26. Twice during a November 2001 personnel security interview, the individual stated that he did not feel he then had an alcohol problem, *Id.* at 23, 35, and stated that he had "no intentions of abusing alcohol in the future." DOE Exhibit 1-4. The DOE determined that the individual should continue to hold a clearance. This decision was followed approximately seven months by the individual's July 2001 arrest discussed above, which led to the present proceeding.

All of the concerns in the present case relate to the individual's use of alcohol.[2] Both the DOE psychiatrist and the individual's treating physician, who has been certified by the American Society of Addiction Medicine since 1986 and has worked "with addicts and alcoholics for the last 15 years or so," Tr. at 135, agree that the individual meets the criteria for Alcohol Dependence, and the individual described himself at the hearing as "alcohol dependent" and "an alcoholic." DOE Exhibit 2-7; Tr. at 72, 108-09, 114. Excessive use of alcohol raises a security concern due to the heightened risk that an individual's judgment and reliability will be impaired to the point that he will fail to safeguard classified matter or special nuclear material. *E.g.*, *Personnel Security Hearing*, 28 DOE ¶ 82,857, Case No. VSO-0479 (2002).

B. *Whether the Security Concerns Have Been Resolved*

A hearing under Part 708 is held "for the purpose of affording the individual an opportunity of supporting his eligibility for access authorization," i.e., "to have the substantial doubt regarding eligibility for access authorization resolved." 10 C.F.R. § 710.21(b)(3), (6). "In resolving a question concerning an individual's eligibility for access authorization," I must consider

[2] For this reason, though the Operations Office cites Criteria H, J, and L of the Part 710 regulations, I do not discuss separately below the security concern as it relates to each of the criteria.

> the nature, extent, and seriousness of the conduct; the circumstances surrounding the conduct, to include knowledgeable participation; the frequency and recency of the conduct; the age and maturity of the individual at the time of the conduct; the voluntariness of participation; the absence or presence of rehabilitation or reformation and other pertinent behavioral changes; the motivation for the conduct; the potential for pressure, coercion, exploitation, or duress; the likelihood of continuation or recurrence; and other relevant and material factors.

10 C.F.R. § 710.7(c).

In the present case, there is no dispute that the individual has abstained from drinking alcohol since his arrest for Public Intoxication on July 6, 2001. Because the individual presents no apparent security concern so long as he continues to abstain from using alcohol, the critical factors in this case are the absence or presence of rehabilitation and the likelihood of recurrence of the individual's habitual and excessive drinking.

The DOE psychiatrist explained in his November 22, 2001 report why he did not believe there was adequate evidence of rehabilitation or reformation in the individual's case.

> The subject went through an extensive alcohol-rehabilitation program in the military a decade ago. In addition, he also went through a religious-sponsored counseling program the following year. In spite of this, he has relapsed at least twice in the past two years, in November of 1999 and in July of 2001. During both relapses he became intoxicated and he was arrested in July of 2001 for Public Intoxication. Therefore, these can not be considered "minor slips." Rather, they are serious relapses. In addition, he has no insight into the fact that he is alcoholic, in spite of the VA hospital and the [Air Force] Alcohol Treatment Program having diagnosed him as such. He also appears not to have a good understanding of alcoholism, including the fact that it is a time-independent trait, rather than a time-dependent state.

DOE Exhibit 3-7 at 35. In response to the DOE psychiatrist's conclusions regarding the individual's lack of insight, the individual stated the following at the hearing:

> I have never denied that I've had a problem with alcohol. I've been asked in the past if I believe that I was an alcoholic and I have said no, which is -- and the reason behind that is due to my spiritual beliefs, which are God and the Bible. I have been taught that drinking to drunkenness is a sin and that I should not do it.
>
> Through meeting with [my treating physician], we've discussed the issues, as far as the medical world and the religious world and how they differ from each other, and there are some vast differences in terminology and agreement on how to deal with some of these -- how to deal with some items, but with this . . . in mind, whether I classify myself as an alcoholic or as a drunkard, per the Bible, it is a moot point to me, I have a problem, and I'm

> willing to do whatever it takes to maintain sobriety regardless of whether or not my access authorization is reinstated.
>
> To me, I do have an alcohol problem, and I've had an alcohol problem for many years. I don't deny that I do. It's just when I'm asked a specific question about being an alcoholic in the past, I really didn't understand that term, and based on my spiritual beliefs, I've been told to pretty much reject that, but I do believe that I have an alcohol problem, and when it comes to [the DOE psychiatrist's] field, or [my treating physician's] field, yes, I would classify myself as an alcoholic.

Tr. at 71-72. After hearing this statement from the individual, the DOE psychiatrist stated, "Well, I think you're saying things now that you didn't say when I examined you, so that you're, I would say, on the road to recovery." Nonetheless, when asked about the individual's risk of relapse, the DOE psychiatrist opined that the individual had a greater than 50 percent chance of relapsing within the next 5 years. Tr. at 104-05.

The physician who has treated the individual and who testified on the individual's behalf at the hearing stated, "I would be astounded if you had a relapse within this five-year period. I think the chance is less than ten percent." Tr. at 123. When asked the same question again later at the hearing, he stated, "I said less than ten percent. I'm tempted to say zero, but I'm not that stupid. I suppose there is a chance of it, but I can't foresee any circumstance that's going to happen. He'd walk away from this job tomorrow if it meant he had to drink to keep it. It just isn't going to happen." Tr. at 154-55.

The discrepancy between the opinions of these two qualified experts is significant, as the individual's physician acknowledged:

> I interpret a lot of this, obviously, vastly different from [the DOE psychiatrist], but a lot of it is in light of what [the individual is] willing to do now.
>
> For what it's worth, you know, I think perhaps one difference between me and [the DOE psychiatrist] -- or a couple of differences, you know, is I've not written books, I've not published all those articles, but all I've done is work with addicts and alcoholics for the last 15 years or so. I see them day in and day out. Over time, I've been fooled. There have been some that I thought would make it and people -- and they didn't, and I've been surprised by people that stayed clean that I didn't think they would, and vice versa. So it's an unpredictable field, you know, and we're making guesses when we predict somebody's ability to stay clean or sober.
>
> . . . .

> But over time -- but I think in the last four or five years, I've gotten pretty good at it. I mean, I haven't been blown out of the waters -- I can't remember the last time I made a prediction like this and was proven wrong, actually.

Tr. at 135-36. The DOE psychiatrist offered a different explanation for the discrepant prognoses, pointing to a "conflict" faced by the individual's treating physician.

> So I always found that somewhat of a conflict when I was practicing, and I'd have to fill out like a Social Security disability for somebody or workmen's compensation for somebody, and, you know, this is my patient, it's my responsibility to do what's in their best interests, so I think in -- when you're on the edge, you tend to -- in those instances, to do what's best for your patient. So that's the only thing I could say that might be different between where we're both sort of coming from in this.

Tr. at 172.

Another possible difference I raised at the hearing was the fact that the individual's treating physician has had more extensive and more recent interaction with the individual than has the DOE psychiatrist. The DOE psychiatrist discounted this as a factor:

> [DOE Psychiatrist]: No. Just because he's seen him more times -- you know, he's seen him five times -- I mean, the typical managed care office visit is, you know, 40 minutes, or so, and the follow-up visit could be 20 minutes or half an hour or 15 minutes.
>
> So, I mean, I have seen him for two hours, but I don't know what I would --
>
> [Individual's Physician]: But you only saw him that one moment in time.
>
> [DOE Psychiatrist]: Right. But I have 20 years' worth of moments in time in terms of his file, in terms of, you know, his history, and reading that, I get a longitudinal picture of somebody. There is lots of information in his security file about somebody over time.
>
> MR. GOERING: Up to November of [2001] --
>
> [DOE Psychiatrist]: The point that I saw him.
>
> MR. GOERING: Now --
>
> [DOE Psychiatrist]: Let me say something. I'm a little bit skeptical about sort of suddenly finding the way, or this -- it's like finding God, all of a sudden, or finding, you know, the answer all of a sudden.

> Most of what we know about addiction and dependence is that it's sort of more of a gradual process. So I'm just a little bit skeptical that, you know, [the individual] sort of has found something between November and December, in that one month, other than the shock of seeing my report that wasn't favorable to him.
>
> It's usually a process, rather than sort of an ah-ha event. So it just makes me a little bit skeptical.
>
> MR. GOERING: Although, in hindsight . . . , looking over the course of a period of a person's life, . . . there is a point -- assuming that they never partake again, in hindsight, there was some moment where . . . something happened to make him not relapse in the future.
>
> [DOE Psychiatrist]: Right, and it could have been my report, because I think he could have seen that alcohol had a big impact on his military career, and then now all of a sudden alcohol is having a big impact on his [DOE facility] career, so that could have been a major kind of jolt, but, you know, I guess -- well, to me, he is showing evidence of rehabilitation or reformation, it just boils down to is it adequate.

Both experts acknowledge that certain generalizations can be drawn from research on addiction and recovery. *E.g.*, Tr. at 163. However, in evaluating the testimony of the two experts, I found a greater willingness on the part of the individual's treating physician to see beyond those generalizations in the individual's case. Rather than the other possibilities discussed above, I believe this to be primarily responsible for the difference between the two prognoses offered in this case.

For example, the DOE Psychiatrist appears to allow for no possibility of adequate rehabilitation or reformation from alcohol dependence in any less than two years.

> [DOE Counsel]. So it's been nearly 12 months or a year. Does that weigh into your consideration in terms of his potential for relapse?
>
> [DOE Psychiatrist]. I think if you can go one year, your risk of relapse is better than if you've only gone a couple of months, but the problem is that his pattern is long periods of abstinence and then relapsing.
>
> I can say, also, just for the record, that I've changed my recommendations over the years. I used to recommend a year to show adequate evidence of rehabilitation or reformation, but I've had many repeat evaluations of people that I've evaluated over the years and I've just become more conservative.
>
> I rarely ever recommend a year, except, as I said before, somebody with alcohol abuse, with no history of going through treatment, but two to three years is, I think, a lot more reasonable given what the stakes are and what the issue is.

Q. If [the individual] produces evidence today, . . . that he's attended maybe 30 to 40 sessions of AA, and that's just a guess, he can confirm that later, since January of this year, does that weigh in on your evaluation? Does that change your recommendation at all?

A. I haven't heard what he said. You know, *the minimum I would always have is two years. So it would never go down to one year, you know, unless I -- well, let's say for all practical purposes it's been one year since his last drink, but no matter what he says*, I would not agree to that.

The minimum would be -- for somebody with alcohol dependence, that's relapsed after going through treatment and who said they would never drink again, it would be two years.

Tr. at 66-68 (emphasis added).

In contrast to the above testimony, the individual's treating physician testified as follows regarding "the appropriate time frame" for showing rehabilitation or reformation.

It's not any -- I don't think you can write it down. I think it depends on the person, the history. In your case, you know, I think you met it. I'm not sure I can really put it in writing. I mean, you've got this huge block of sobriety, with a couple of relapses that have been disastrous, and you've made an effort to make sure they don't occur again, and you've made tremendous progress, I think, especially compared to where you were.

So I don't think you can -- I think -- I don't think you can create a recipe that somebody has to fit and everybody needs to fit in there.

Just from my experience in working with addicts, you know, there is just too much variability from one case to the next. There are some people that I've seen that have had ten years clean that I wouldn't trust them another 30 seconds, . . .

As would be expected, the physician's testimony also reflects more in-depth knowledge and understanding of the individual's recovery efforts.

I've looked through [the DOE Psychiatrist's report]. Of course, my opinion is different on this because I've known you in a different capacity than [the DOE Psychiatrist] has known you.

Actually, I spoke with you as early as probably December and January, and I finally met you in April once I went into private practice. I spent a couple of hours with you the first time, and I've had four or five visits with you since.

A lot has happened since then. You've been attending AA meetings on a regular basis three times a week. You're recording that. You've had a lot of conversations about this conflict

with religion and the 12-step program, the medical model and the disease concept, and I think that I have a pretty good understanding of where you're coming from on that, and I think you also understand where I, and most of us in the medical profession, are coming from on that, and I think basically you're pretty much in agreement with our philosophy about the diagnosis and about the concept of staying clean and so forth.

> You've asked for Antabuse, you're on Antabuse now, and you did that on your own. You understand that Antabuse is something that you can take theoretically indefinitely, but most people I put Antabuse on just use it, mentally, when they are in periods of crisis.
>
> We've talked about you coming off of Antabuse during periods of stability. When things in your life are rocky, when they are unstable, if you're in a marriage that's not going well, if you're headed for divorce, if you're going out of town for a family reunion or somebody else's wedding, you've already agreed you would ask for Antabuse and take it in preparation for that trip. It's going to last for seven days, so if you take it a week before you go, you don't have to take it there, it would still be effect, and you don't think you would drink if you were taking Antabuse, and I think that's helpful.
>
> . . . .
>
> I offered things like Antabuse and Revia, Maltrexone, and we talked about them a lot, and I didn't have any real strong feelings.
>
> I don't feel that anybody should be pressured to take any of those medications, but I always offer them, and he felt that . . . the Antabuse would be preferable, because he knows that on Antabuse he can't drink. Revia, he actually rejected, because he knows -- he knows that he could take Revia and he could still drink and get away with it.
>
> Revia, supposedly, decreases cravings for alcohol, and so if you have a serious alcohol problem and you drink and go off the deep end, if you're on Revia, you can stop at a couple of drinks, you don't go off the deep end, as he's done. You have fewer cravings. So a lot of people, if given a choice between the two drugs, will choose Revia because they feel that Revia will enable them to be a controlled drinker.
>
> What I find is that people that haven't made a decision to give it up yet will choose Revia, because they feel if they are on Revia that they are not as likely to get in trouble, but -- and yet they can still drink, but he didn't choose that, he chose Antabuse, because he didn't want to drink at all, and I thought that was significant.

Tr. at 114-16, 129-30.

The physician contrasted the individual's current rehabilitation efforts with the treatment he received in the early 1990s.

> If you're in the military and your commanding officer thinks you've got a problem, you go to treatment. You go, and you don't have much really to say about it. You just go and you do it.
>
> . . . .
>
> He says you're an alcoholic, okay, you're an alcoholic. You go through it. But what that does, unfortunately, is you build up all these resentments, you get all this anger about the fact that you're having to do it and you don't want to do it, and one of the worst things you can do to an alcoholic is force them into treatment when they are not ready, because then it sours them for the experience in the future.
>
> I think the experiences then actually had an impact on his mental attitude and impression of AA and all this now and there are some hurdles that he's had to get over because he was forced into that back then.
>
> There was no question that he was an alcoholic back then, but he wasn't ready yet, he hadn't made those quantum changes, he hadn't come to terms with it, he hadn't had enough consequences yet at that time, he still felt, I suspect, but he didn't tell me this, but I suspect, like he could control this, he could somehow dictate what his future was going to be with alcohol. He had to have some of these unpredictable consequences, some of these unpredictable relapses, to really come to terms with how bad this was.

Tr. at 136-37.

Bolstering the prognosis of the individual's treating physician was the testimony of the individual, who words and demeanor reflected a keen desire to succeed in maintaining his sobriety:

> I have a support system in place . . . for now, I've got [my treating physician], I've got AA, I've got numbers of people from AA, people that I trust and actually think pretty much along the same lines I do. I have Antabuse that I can use, if I feel that I'm going to be in a situation that may lead to drinking, okay, and even though I don't plan on drinking, . . . I've got [the DOE's Employee Assistance Program] to utilize. I've got friends, my ex-wife is one of the big ones, I guess, that I can talk to about -- about my drinking problem. I've got church -- a huge one. I don't really have contacts there, but the Bible and the people that I hang out with there are just awesome, and I can utilize them as a tool.
>
> Some of these things I had in place before, and I believe that they are strong reasons why I had gone long periods of time without alcohol. The things that scare me are those few individual points in my -- when I have not wanted to drink that I have to identify and have a plan of action for, and those are what's important to me, and I believe they are important to you, what do I have in place at that point in time. I've covered those as well.

[DOE Counsel]. No, I think that's -- no, no, that's great. Thank you.

. . . .

Just a follow-up on that.

What are your intentions? I mean, do you plan on staying in the weekly AA meetings that you have now indefinitely, or how long do you see that continuing?

A. AA itself?

Q. Yes.

A. For now, I'm going to keep going three times a week.

Q. Do you see yourself --

A. Indefinitely?

Q. Yes.

A. I plan on continually going to AA.

Tr. at 281-83.

The strength of the individual's support system and his active participation in AA was evident from the testimony of the individual's ex-wife, one of his friends (though it appears that the other friend who testified is not aware of the individual's alcohol problem), his treating physician, and the leader of one of his weekly AA meetings. Tr. at 204-45.

III. *Conclusion*

Although it is impossible to predict with absolute certainty an individual's future behavior, the Part 710 regulations call for me to make a predictive assessment. The DOE psychiatrist provided thoughtful and sound testimony as to the process of recovery, and risk of relapse, *in general*, that reflected his long experience in evaluating cases of substance abuse and dependence. However, I found the individual's treating physician's testimony to be more helpful to my predictive assessment regarding *the individual*.[3] While my opinion as to the risk of relapse in the individual's case is not

[3] I also find persuasive authority for my conclusion in the government-wide guidelines that were appended "for reference purposes" to the Part 710 regulations, as revised in 2001. 66 Fed. Reg. 47061, 47067 (September 11, 2001). Those guidelines include the following as a "condition[] that could mitigate security concerns:"

> Following diagnosis of alcohol abuse or alcohol dependence, the individual has successfully

as optimistic as the individual's physician ("As certain as I can be."), Tr. at 152, I find that the chance of such a relapse is low enough that what risk it does present is acceptable. For the above-stated reasons, "after consideration of all the relevant information, favorable and unfavorable," I conclude that restoring the individual's "access authorization would not endanger the common defense and security and would be clearly consistent with the national interest." 10 C.F.R. §§ 710.7(a), 710.27(a).

Steven J. Goering
Hearing Officer
Office of Hearings and Appeals

Date: September 9, 2002

> completed inpatient or outpatient rehabilitation along with aftercare requirements, participated frequently in meetings of Alcoholics Anonymous or a similar organization, has abstained from alcohol for a period of at least 12 months, and received a favorable prognosis by a credentialed medical professional or a licensed clinical social worker who is a staff member of a recognized alcohol treatment program.

Id. at 47069. In the present case, the individual has clearly abstained from alcohol for a period of over 12 months, participated frequently in AA meetings, met the requirements for rehabilitation set by a credentialed medical professional, and has received a favorable prognosis from that professional. Tr. at 152.